Iowa Department of Human Services

Attestation of Medical Record Loss or Destruction

Due to extenuating circumstances beyond my control, documentation is not available in support of my Medicaid claim(s). I attest that the documentation was destroyed as a result of a disaster for which the Governor issued a Disaster Proclamation in the county where the records were located. (Complete 1 or 2 and then move on to number 3):

☐ 1. The records were completely destroyed.
Provide the date and the location of the records at the time they were destroyed:
Date destroyed: _____
Location of records at the time of destruction: _____
_____

Or

☐ 2. The records were partially destroyed and rendered unreadable and unusable on (Date) _____.

The remains of partially destroyed records were disposed of by (indicate date, method, and responsible party):
_____
_____

3. Short description of complete or partially destroyed records:
_____
_____
_____

4. Medicaid Member name_____ State ID Number _____

☐ I certify that the above information is true, accurate, and complete.
☐ I certify that I am an owner or an individual legally authorized to act on behalf of the owner(s) or providers(s).

_____ _____
Name and Title (please print) Relationship to Provider

_____ _____
Signature Date

_____ _____
Provider Name Provider Billing Number

Please fill out the following **additional** information if this form is being submitted as documentation in order to obtain payment of a Medicaid claim:
☐ I understand that payment of this claim(s) will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.
☐ Submitter Medicaid ID Number (if different than billing provider number): _____
☐ Total Number of Claims Submitted with this Letter of Attestation: _____
☐ Total Billed Charges of Claims Submitted with the Letter of Attestation: _____

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(For internal use only) DHS/IME approval: ☐ Yes ☐ No

Attestation of Medical Record Loss or Destruction

Instructions and Information

Please note: This form can only be used for documents that were partially or completely destroyed, as a result of a recent declaration of disaster by the Governor of the State of Iowa.

All the appropriate fields on the form must be accurately and legibly complete.

On #3, list the time period of the records that were completely or partially destroyed.

If utilizing the form as documentation that must be maintained for five years for potential audit or review purposes, one form must be filled out and maintained for each individual Medicaid Member.

The signature must be that of the owner, provider, or the individual legally authorized to act on behalf of the owner or provider.

If utilizing the form as documentation that is required to be submitted in order to obtain payment of a Medicaid claim, please note the following:

- ✓ Only the “Attestation of Medical Record Loss or Destruction” will be accepted for this process. No other “attestations” will be considered.
- ✓ Do not use “white correction fluid” on any portion of the form or claims.
- ✓ Other forms or claims will be returned without processing if used.
- ✓ A separate attestation must accompany each batch of hard copy claims or CD/electronic transaction.
- ✓ Claims without the appropriate attestation form will be returned without processing.